

No. 2
4-13-40
-17-39
I X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 22 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37416

State File No.

Registration District No. 399

Primary Registration District No. 1602

Registrar's No. 4211

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1326 Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)
In this community 25 years

3. (a) PRINT FULL NAME Nora Turner
(b) If veteran, name war No
(c) Social Security No. None

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife unknown
(c) Age of husband or wife if alive years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years Approx 71 Months Days If less than one day hr. min.

9. Birthplace Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER
12. Name Mrs. Turner
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Turner
(b) Address 2015 E. 24th St. Terrace

17. (a) Burial (b) Date thereof 11-12-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director G. Sterling

(b) Address 1212 W. 12th St. St. Louis, Mo.

19. (a) 11-12-41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1326 Highland
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 6 year 1941
hour 3:30 minute P.M.

21. I hereby certify that Coroner the deceased from 3:30 P.M. to 19 that he was alive on 11-6-41 and that death occurred on the date and hour stated above.
Immediate cause of death Hemiparesis
Rupture of ascending aorta
Duration

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 96
Of autopsy 96
Due to rupture of ascending aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 96
(b) Date of occurrence 11-6-41
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work 96 (Specify kind of place) (e) Means of injury 96

23. Signature W. H. Baker (M. D. or other)
Address W. H. Baker Date signed 11-6-41

3

(Handwritten mark)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *E. Sterling Bills*

Licensed Embalmer No. *3178*

P. O. Address *1212 Vine St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37414**
Registrar's No. **4211**

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1326 Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT
FULL NAME

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **♂** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife.....
6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Approx 71 hr. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **8/30/54** (b).....
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No.....
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Nov** day **6**
year **1954** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
..... 19..... to..... 19.....
that I last saw h..... alive on.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Myocardial infarction
Due to **Rupture of ascending aorta**
Due to **Medial necrosis of the aorta**
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?.....
(Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-37416